In summary, there is coverage in the course of the "every-day" ethical questions, attention to medical-legal issues, and attention to some of the medical ethical issues that generate serious and concerned discussion in the general population and in the medical profession. We are providing experiences in a non-threatening classroom setting that we believe will later be useful in the student's professional career.

Additional opportunities to explore ethical issues occur in connection with topics covered in other basic science courses, although necessarily there is less focus on the ethical issue. The students in their last two years of medical school will be exposed to many patients with ethical problems. The setting will be clinical, the problems immediate and real.

We believe the experiences they have had in the Human Behavior and Development course will allow them to grasp more effectively the significance and complexity of ethical issues they encounter in their clinical training. ■

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Medicare Assigned and Unassigned Claims: What Do They Mean?

In our consulting work, as well as in our workshops, we continue to find large numbers of physicians, office managers, billing, and insurance personnel who do not understand the fundamental differences between assigned and unassigned Medicare claims, and the practice's and patient's rights and obligations. The errors that continue to occur relative to these terms have cost, and will continue to cost, thousands of dollars for individual practitioners throughout the United States. Not only does this do the practice a disservice, but it also does a disservice for patients in general because it may result in doctors raising fees to their non-Medicare patients to much higher amounts than might otherwise be necessary.

Arizona's Aetna/Medicare organization publishes a booklet entitled, *Aetna's Guide to Medicare - Part B* which is currently in its sixth edition, and is somewhat out-of-date. Unfortunately, the booklet was published prior to the passage of public law 99-509, the OBRA law, passed in October 1986, dealing with Maximum Allowable Actual Charges (MAAC). It is not our intent to explore the implications of that law, because they are far too complex to discuss in a journal article. We feel it is essential, however, to explain the rules and regulations pertaining to assignment and non-assignment of Medicare benefits. We would still strongly suggest that every practitioner in the State write to the Professional Relations Department of Aetna/Medicare, and request a copy of this booklet (the address is at the end of this article.).

Assignment of Medicare benefits means that both the doctor and the patient have agreed and authorized Medicare to forward payment directly to the physician. By the physician's agreement to do this, the physician also agrees that he will accept whatever Medicare *approves* as payment in full. Note that the operative word here is "Medicare *approved*." Medicare will forward a check to the doctor for 80% of the *approved* amount. *This does not necessarily represent the maximum amount that the physician may collect from the Medicare patient*. Except in the case of certain pathology procedures, and certain outpatient surgery procedures approved by Medicare, the patient will be liable for both an anual deductible of $75, as well as a *co-payment of 20% of the Medicare approved amount*. For instance, if the doctor's customary fee or MAAC was $140, but Medicare *approved* $100 (because the doctor has agreed to accept Medicare's *allowed* amount through assignment), Medicare would forward a check to the practitioner in the amount of $80. This would leave the patient, or the patient's co-insurance company, with a balance of $20 (20%) of the Medicare *approved* amount. When a doctor agrees to accept assignment, he agrees that no additional amounts over and above the Medicare *approved* amount will be billed to the patient, or to the patient's supplemental insurance carrrier.

Unfortunately, many physicians and medical office insurance personnel believe that the payment (80% of the *approved* charge) is all they are entitled to, and all they may collect when they have accepted assignment from Medicare. Not only is this an incorrect interpretation of assignment, it

may be considered a technical violation of the Medicare regualtions, potentially resulting in money penalties, but, much worse, it may result in the doctor's customary fee profile or MAAC being reduced during the next fee screen period. In the example cited above, if the doctor accepted the $80 as payment in full for the service on all of his Medicare patients, he might find his customary charge or MAAC reduced to $80 during the next calendar year. This would mean that in that following year, the doctor's approved charge would be $80 instead of $140. Consequently, the doctor would receive only $64 from Medicare on assigned claims. In the case of non-participating physicains, the doctor's new MAAC of $80 would be the maximum he would be allowed to bill for these services, *whether he accepted assignment or not!*

Most physicians accept assignment from Medicare patients on a case-by-case basis. This is the major reason we have found for physicians choosing not to participate in the Medicare program. A non-participating physician can elect to accept assignment on one Medicare patient and not accept it on another; he may accept assignment today on a Medicare patient for hospital services, and not accept assignment on the patient tomorrow for office services, or vice-versa. Participating physicians, on the other hand, must accept assignment on all Medicare patients at all times. A Medicare patient surviving on a minimum Social Security income would probably not have enough money to pay for supplemental insurance. In these situations, if the doctor elects to accept Medicare payment as payment in full, he may do so, although we suggest that the doctor place the patient through their normal billing cycle before reaching such a decision. If the money is truly uncollectible, Medicare cannot hold the physician responsible for not collecting it. However, no one would be able to accept the fact that *all* of the Medicare patients in a medical practice could not pay the co-insurance.

One added pointer for particpatig physicians is that *it is authorized* for them to collect deductibles and co-payments when the patient is in the office. This was explicitly described in the fact sheet distributed to physicians in November of 1986 on the implementation of public law 99-509 (the famous "Dear Doctor" letter.).

Non-assigned Medicare claims are only possible when a physician has elected to be a non-participant in the Medicare program. If a physician is a non-participant, he may elect to bill a patient his full Maximum Allowable Actual Charge (MAAC), even if this charge is in excess of the prevailing Medicare charge for the area. In those situations in which the doctor's MAAC is in excess of the Medicare prevailing amount, and he chooses not to accept assignment, the doctor is entitled to collect the fee up to the full MAAC amount. For example, if the doctor has a MAAC of $155 for a procedure and Medicare has a prevailing fee for that procedure of $110, *the doctor may hold the patient responsible for the entire charge.* In this situation, *the patient would receive the Medicare check* for $88. If the patient has co-insurance through AARP or some

other similar retirement program, the retiree program would, in most cases, pay the difference between the $88 and the $110 Medicare prevailing fee, $22. The patient would then owe $45 out of his own pocket. It should be noted that some Medicare supplementary carriers will pay the entire difference between the doctor's Maximum Allowable Actual Charge and the Medicare approved amount. In fact, most so-called "high option" Medicare supplemental plans have such provisions. Unfortunately, it's very difficult to ascertain which patients have these "high option" plans, other than by reviewing the policy.

Whether a practice is participating or non-participating, they can have a Medicare patient sign a lifetime authorization for assignment of benefits. The statement that the patient must sign is listed on page 7 of the booklet, *Aetna's Guide to Medicare - Part B.* Once this lifetime assignment is accepted by the physician, he may then submit claims to Medicare by simply inserting the phrase "patient's request for payment on file" in blocks 12 and 13 of the Universal Claim Form (HCFA-1500). It should be noted that in order for assignment to be accepted by Medicare, block 13 must have the patient's signature or the statement listed above inserted, *and* the doctor must indicate his acceptance of assignment in block 26 of the Universal Claim Form. If this block is not checked, Medicare will assume that assignment is not accepted, and payment will be forwarded to the patient.

In conclusion, doctors must understand that accepting assignment does not mean that the payment received from Medicare is payment in full for Medicare-assigned services. Furthermore, doctors must understand that it is always essential that they charge their full Medicare approved charge for all services rendered to Medicare patients. If this is not done, it may have a detrimental effect on the doctor's customary (for participating physicians) fees or on the doctor's Maximum Allowable Actual Charge (for non-participating physicians) in coming years. Practices are strongly encouraged to contact the Provider Relations Department of Aetna-Medicare, P.O. Box 37200, Phoenix, Arizona 85069 for the booklet mentioned above, if they have not already received a copy. ■

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Manager

The 96th Annual Meeting

of the

Arizona Medical Association

will be held

June 4 - 6, 1987

at

The Pointe at South Mountain

7777 South Pointe Parkway, Phoenix, Arizona

THURSDAY, JUNE 4
All Day
Current Perspectives
C.M.E. Programs

Evening
Casual Reception
Dinner

FRIDAY, JUNE 5
6 a.m., Executive Committee
8 a.m., Board of Directors
10 a.m., House of Delegates

Noon, Past Presidents' Luncheon
2 p.m., Reference Committees
President's Reception & Banquet

SATURDAY, JUNE 6
8 a.m., House of Delegates
Noon, Board of Directors